Instructions for Completing the American Dental Association (ADA) 2012 Claim Form

Iowa Medicaid Dentists bill for Medicaid-covered services using the 2012 *Dental Claim Form* published by the American Dental Association.

The billing instructions below contain information that will aid in the completion of the ADA 2012 claim form. The table follows the claim form by field number and name, giving a brief description of the information to be entered, and whether providing information in that field is required, optional or conditional of the individual recipient's situation.

The Iowa Medicaid Enterprise provides software for electronic claims submission at no charge. For electronic media claim (EMC) submitters, refer also to your EMC specifications for claim completion instructions. For assistance with setting up or questions related to electronic billing, contact EDI Support Services at 800-967-7902, email support@edissweb.com, or visit http://www.edissweb.com/med/.

When submitting a paper claim to Iowa Medicaid, the claim form must be typed or handwritten legibly in dark blue or black ink. Mail to:

Medicaid Claims
P.O. Box 150001
Des Moines, IA 50327

Field No.	Field Name/ Description	Requirements	Instructions
1	Type of Transaction	**REQUIRED**	Check "Statement of Actual Services" if the statement is for actual services. Check "EPSDT/Title XIX" if the services are a result of a referral from an EPSDT *Care for Kids* screening examination. ***Note:*** Requests for predetermination/preauthorization should be completed using the prior authorization form.
2	Predetermination/ Preauthorization Number	*SITUATIONAL*	Required if Medicaid has assigned a predetermination/Prior authorization number for the services. Enter the prior authorization number for the services.

Insurance Company/Dental Benefit Plan Information			
3	Company/Plan Name, Address, City, State, Zip Code	**OPTIONAL**	No entry required.
Other Coverage			
4	Other Coverage	**REQUIRED**	Check if the member has other medical or dental insurance. If Box 4 is checked an amount must be entered in Box 31a. If carrier denied "$0.00" must be entered. **Note:** Medicaid should be billed only after the other insurance plans have been billed. If one box is checked, Boxes #5-11 must be completed. If both of the boxes for Dental and Medical coverage are checked, enter only the other Dental carrier information in Boxes 5-11.
5	Name of Policyholder/ Subscriber in #4	*SITUATIONAL*	Required if the patient has other insurance. Enter the last name, first name, and middle initial of the primary subscriber.
6	Date of Birth	*SITUATIONAL*	Required if the patient has other insurance. Enter the date of birth of the primary subscriber. Entry should be made in MM/DD/YYYY format.
7	Gender	*SITUATIONAL*	Required if the patient has other insurance. Check the appropriate box for the primary subscriber's gender.
8	Policyholder/ Subscriber ID	*SITUATIONAL*	Required if the patient has other insurance. Enter the other insurance ID# or the SSN of the primary subscriber.

9	Plan/Group Number	*SITUATIONAL*	Required if the patient has other insurance. Enter the plan/group number for the other insurance of the primary subscriber.
10	Patient's Relationship to Person Named in box # 5	*SITUATIONAL*	Required if the patient has other insurance. Check the appropriate box to reflect the relationship the Patient has with the policyholder named in #5.
11	Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code	*SITUATIONAL*	Required if the patient has other insurance. Enter the name, address, city, state, and zip code of the other insurance company/dental benefit plan.
Policyholder/Subscriber Information			
12	Policyholder/Subscriber Name, Address, City, State, Zip Code	**REQUIRED**	Enter last name, first name, and middle initial of the Medicaid member. Use the *Medical Assistance Eligibility Card* for verification.
13	Date of Birth	**REQUIRED**	Enter the date of birth if the member. Entry should be made in MM/DD/YYYY format.
14	Gender	**REQUIRED**	Check the appropriate box for the member's gender.
15	Policyholder/ Subscriber ID	**REQUIRED**	Enter the Medicaid identification number of the member. This number consists of seven numbers and a letter, i.e. 1234567A. This number can be found on the *Medical Assistance Eligibility Card.*
16	Plan/Group Number	OPTIONAL	No entry required.
17	Employer Name	OPTIONAL	No entry required.
Patient Information			
18	Relationship to Policyholder/Subscriber in #12	OPTIONAL	No entry required.
19	Reserved for Future Use	OPTIONAL	No entry required.

20	Name, Address, City, State, Zip Code	OPTIONAL	No entry required.
21	Date of Birth	OPTIONAL	No entry required.
22	Gender	OPTIONAL	No entry required.
23	Patient ID/ Account #	OPTIONAL	Enter the number assigned by the Dentist's office relating to the patient's account or the record number. This field is limited to 20 characters.
Record of Services Provided (For Insurance Company Named in #3)			
24	Procedure Date	**REQUIRED**	Enter the date of service. Entry should be made in MM/DD/YYYY format. ***Note:*** One entry is required for each line billed.
25	Area of Oral Cavity	*SITUATIONAL*	Report the area of the oral cavity unless one of the following conditions in #29 (procedure code) exists: * The procedure identified in #29 requires the identification of a tooth or a range of teeth. * The procedure identified in #29 incorporates a specific area of the oral cavity (for example: D5110 complete denture – maxillary). * The procedure identified in #29 does not relate to any portion of the oral cavity (for example: D9220 deep sedation/general anesthesia – first 30 minutes). *Note: The ANSI/ADA/ISO Specification No. 3950 – 1984 Dentistry Designation System for Teeth and Areas of the Oral Cavity* should be used in reporting the area of oral cavity. Valid entries are: **00** Whole of the oral cavity **01** Maxillary area **02** Mandibular area *… Continued on next page*

			10 Upper Right quadrant **20** Upper Left quadrant **30** Lower Left quadrant **40** Lower Right quadrant
26	Tooth System	OPTIONAL	No entry required.
27	Tooth Number(s) or Letter(s)	*SITUATIONAL*	When billing an applicable procedure code. Enter the tooth number (permanent teeth) or tooth letter (deciduous teeth). **Note:** *The ADA's Universal/National Tooth Designation System* is to be used in reporting tooth number/letter. If the same procedure is performed on more than one tooth, on the same date of service, report each procedure and tooth designation on *separate lines* on the claim form. If billing for partial dentures, *one* tooth number from the area of the denture is required. If the area contains both anterior and posterior teeth, an anterior tooth number should be used.
28	Tooth Surface	*SITUATIONAL*	When billing an applicable procedure code. Enter the standard ADA designation of the tooth surfaces.
29	Procedure Code	**REQUIRED**	Enter the appropriate procedure code found in the version of the *code on dental procedures and Nomenclature* in effect on the "procedure date" (#24).
29a	Diag. Pointer	*SITUATIONAL*	Required if a diagnosis code is entered in Box 34a. Indicate the corresponding diagnosis code from Box 34a by entering the letter of its position, i.e. "A". **DO NOT** enter the actual diagnosis code in this field, doing so will cause the claim to deny.

29b	Qty	*SITUATIONAL*	Required when billing D9221 or D9242. Enter the number of units provided.
30	Description	**REQUIRED**	Enter a description of the procedure.
31	Fee	**REQUIRED**	Enter the usual and customary charge for each line item billed. ***Note:*** The total must include both dollars and cents. Do not enter the fee from the Medicaid fee schedule.
31a	Other Fee(s)	*SITUATIONAL*	Must be left blank, unless the member has other insurance. Enter the payment amount received from other insurance in relation to the claim. If the other insurance denied the claim or applied the full allowed amount to the coinsurance/deductible enter “0.00”. Do not include the member’s co-payment amount in this box. ***Note:*** The total must include both dollars and cents.
32	Total Fee	**REQUIRED**	Enter the sum of the charges listed in #31 (Fee). This field should be completed on the last page of the claim only. ***Note:*** Do not subtract any amounts paid by other insurance.

Missing Teeth Information			
33	(Place an "X" on each missing tooth)	*SITUATIONAL*	Place an "X" on the missing tooth letter/number. ***Note:*** *The ADA's Universal/National Tooth Designation System* is used to name teeth on the form.
34	Diagnosis Code List Qualifier	*SITATIONAL*	REQUIRED if a diagnosis code is entered in Box 29a. Indicate whether the claim reflects ICD-9 or ICD-10 diagnosis codes. Currently only ICD-9 diagnosis codes are allowed by Iowa Medicaid, therefore "B" should be entered.
34a	Diagnosis Code(s)	*SITUATIONAL*	Only REQUIRED if the member is pregnant at the time of service or received preventive services due to a physical or mental condition that impairs their ability to maintain adequate oral hygiene. If the member is pregnant enter diagnosis code "V22.2". This will indicate that the member is pregnant and exempt from the co-pay requirement. If the member is disabled enter diagnosis code "V49.89" This will allow for reimbursement of preventive services otherwise limited. DO NOT enter descriptions.
35	Remarks	*SITUATIONAL*	Enter the reason for replacement if crowns, partial or complete dentures are being replaced. Enter a brief description if treatment is the result of an occupational illness/injury, auto accident or other accident. *…continued on next page*

			Note: This space may be used to convey additional information for a procedure code that requires a report, or for multiple supernumerary teeth. It can also be used to convey additional information believed necessary to process the claim. Remarks should be concise and pertinent to the claim submission. Pregnancy is now indicated in Box 34a.
Authorizations			
36	Patient/Guardian signature	OPTIONAL	No entry required.
37	Subscriber signature	OPTIONAL	No entry required.
Ancillary Claim/Treatment Information			
38	Place of Treatment	**REQUIRED**	Enter the 2-digit Place of Service Code for Professional Claims, a HIPAA standard maintained by the Centers for Medicare and Medicaid Services. Frequently used codes are: ***Note:*** 03 - School 11 - Office 12 - Home 21 - Inpatient Hospital 22 - Outpatient Hospital 31 - Skilled Nursing Facility 32 - Nursing Facility

39	Enclosures (Y or N)	*SITUATIONAL*	Check box if the claim includes enclosures, such as radiographs, oral images or study models.
40	Is Treatment for Orthodontics?	OPTIONAL	No entry required.
41	Date Appliance Placed	OPTIONAL	No entry required.
42	Months of Treatment Remaining	OPTIONAL	No entry required.
43	Replacement of Prosthesis?	*SITUATIONAL*	Required when billing for crowns, partial or complete dentures. Check the applicable box. If "YES" is checked, then indicate the reason for replacement under "Remarks" in #35.
44	Date Prior Placement	*SITUATIONAL*	Required if "YES" is checked in #43, *and* if prior placement is less than 5 years ago. Enter the date of prior placement. Entry should be made in MM/DD/YYYY format. To verify the date of prior placement contact ELVS at 1-800-338-7752, or in the local Des Moines area at 515-323-9639.
45	Treatment Resulting from	*SITUATIONAL*	Required only if treatment is result of occupational illness or injury, auto accident or other accident. Check the applicable box and enter a brief description in #35.

46	Date of Accident	*SITUATIONAL*	Required only if treatment is result of occupational illness or injury, auto accident or other accident. Enter the date of the accident. Entry should be made in MM/DD/YYYY format.
47	Auto Accident State	*SITUATIONAL*	Required only if treatment is result of occupational illness or injury, auto accident or other accident. Enter the two letter postal state code for the state in which the auto accident occurred.
Billing Dentist or Dental Entity			
48	Name, Address, City, State, Zip Code	**REQUIRED**	Enter the name and complete address of the Billing Dentist or the dental entity (Corporation, group, etc.). ***Note:*** The address must contain the zip code associated with the billing dentist/dental entity's NPI. The zip code must match the zip code confirmed during NPI verification.
49	NPI	**REQUIRED**	Enter the NPI of the billing entity.
50	License Number	OPTIONAL	No entry required.
51	SSN or TIN	OPTIONAL	No entry required.
52	Phone Number	OPTIONAL	No entry required.
52A.	Additional Provider ID	**LEAVE BLANK**	This field must left BLANK. The claim will be returned if information is submitted in this field.
Treating Dentist and Treatment Location Information			
53	Treating Dentist signature	**REQUIRED**	Enter the name of the treating Dentist and the date the form is signed.
54	NPI	**REQUIRED**	Enter the NPI of the treating Dentist.

55	License Number	**REQUIRED**	Enter the license number of the treating Dentist.
56	Address, City, State, Zip Code	**REQUIRED**	Enter the complete address of the treating Dentist. ***Note:*** The address must contain the zip code associated with the treating Provider's NPI. The zip code must match the zip code confirmed during NPI verification.
56A.	Provider Specialty Code	**REQUIRED**	Enter the taxonomy code associated with the billing entity's NPI. ***Note:*** The taxonomy code must match the taxonomy code confirmed during NPI verification.
57	Phone Number	OPTIONAL	No entry required.
58	Additional Provider ID	**LEAVE BLANK**	This field must left BLANK. The claim will be returned if information is submitted in this field.

** If you have any questions about the form or instructions, please contact Provider Services at 1-800-338-7909, locally in the Des Moines area at 515-256-4609.